STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155448	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE CENTER	710 MICHIGAN ST LOWELL, IN46356

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F0000	This visit was for the Investigation of Complaint IN00089914. Complaint IN00089914-Substantiated. Federal/state deficiencies related to the allegations are cited at F281 and F333. Survey dates: May 11 & 12, 2011 Facility number: 000361 Provider number: 155448 AIM number : 100266340 Survey team: Janet Adams, RN, TC Kathleen Vargas, RN (5/12/11) Census bed type: SNF/NF: 69 Total: 69 Census payor type: Medicare: 12 Medicaid: 47 Other: 10 Total: 69 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 5/17/11 by Jennie Bartelt, RN.			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to provide services that met professional standards of quality related to not following the five rights of drug administration for 1 of 1 resident in the sample of 6 reviewed for medication errors, who received an insulin injection that was ordered for another resident. (Residents #B and #C) Findings include: The "Drug Administration Guidelines" in the "2010 Nursing Spectrum Drug Handbook" were reviewed. The guidelines indicated nurses were responsible for applying the "five rights" of drug administration. The five rights included assuring medications were administered to the right patient by	F0281	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. F281 Services Provided Meet Professional Standards 1. Resident #B's insulin was administered according to the physician order. Resident #C was evaluated by the nurse practitioner. Resident #C was monitored for adverse reactions. 2. All residents receiving insulin were reviewed with the nurse to ensure the correct residents received the correct insulin. No other residents were affected. 3. All nursing staff were re-educated regarding the 5 rights of medication administration. Medication passes were observed by the D.O.N. and/or designee. No other medication errors were found during the observations. 4. Medication	06/03/2011

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	confirming the patient's identity. The record for Resident #C was reviewed on 5/11/11 at 5:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, hypothyroidism, high blood pressure, depressive disorder, and chronic airway obstruction. The resident did not have a diagnosis of diabetes mellitus. The 2/2011 physician's orders indicated there were no orders for the resident to receive any insulin injections or oral hypoglycemic (medications to lower blood sugar levels). A "Medication Error Report" completed on 2/4/11 was reviewed on 5/12/11 at 10:20 a.m. The report indicated Resident #C received an injection of 15 units of Humulin 70/30 that was ordered for Resident #B. The insulin injection was given on 2/4/11 at 3:55 p.m. The physician was notified on 2/4/11 at 4:00 p.m. Orders were obtained on		observations will be completedand documented on various shifts, Monday -Friday, three times a week for two weeks then visual observations will be completed weekly ongoing by the D.O.N. and/or designee. Medication observation will be part of the ongoing QA process. The findings will be reported to the QA committee quarterly. 5. These systemic changes were completed on 2/8/11.	

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	2/4/11 to check the resident's blood sugar levels every two hours until 10:00 a.m. on 2/5/11. When interviewed on 5/12/11 at 11:20 a.m., the Assistant Director of Nursing indicated she completed the 2/4/11 Medication Error Report. The Assistant Director of Nursing indicated the staff nurse who administered the insulin injection to the wrong resident reported the medication error to her immediately after it occurred. When interviewed on 5/12/11 at 1:40 p.m., the Director of Nursing indicated staff are to follow the "Rights of Medication Administration" when administering all medications, which includes administering the medication to the right patient. The Director of Nursing indicated the facility protocol is for nursing staff to identify the resident by name, their picture in the medication books, or by asking another staff member.			

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	This federal tag relates to complaint IN00089914. 3.1-35(g)(1)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free of significant medications errors related to an insulin injection of Humulin 70/30 insulin that was not ordered by the physician was administered to 1 of 1 resident reviewed for medication errors in the sample of 6. (Residents #B and #C) Findings include: The record for Resident #C was reviewed on 5/11/11 at 5:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, hypothyroidism, high blood pressure, depressive disorder, and chronic airway obstruction.	F0333	F333 Residents Free of Significant Med Errors 1. Resident #B's insulin was administered according to the physician order. Resident #C was evaluated by the nurse practitioner. Resident #C was monitored for adverse reactions. 2. All residents receiving insulin were reviewed with the nurse to ensure the correct residents received the correct insulin. No other residents were affected. 3. All nursing staff were re-educated regarding the 5 rights of medication administration. Medication passes were observed by the D.O.N. and/or designee. No other medication errors were found during the observations. 4. Medication observations will be completedand documented on various shifts, Monday -Friday, three times a week for two weeks then visual observations will be completed weekly ongoing by the D.O.N. and/or designee. Medication observation will be part of the ongoing QA process. The findings will be reported to	06/03/2011

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	The resident did not have a diagnosis of diabetes mellitus. The 2/2011 physician's orders indicated were no orders for the resident to receive any insulin injections or oral hypoglycemic (medications to lower blood sugar levels). A Physician's order was written on 2/4/11 at 5:00 p.m. for staff to check the resident's blood sugars every two hours until 2/5/11 at 10:00 a.m. A Physician Progress Note completed on 2/4/11 indicated the Nurse Practitioner was asked to evaluate the resident as the resident received a dose of insulin. The Progress Note indicated the the resident's blood sugar immediately afterwards was "250's" and did drop to "50's." The 2/2011 Nursing Progress Notes were reviewed. An entry on 2/4/11 at 5:00 p.m. indicated new orders were obtained from the Nurse Practitioner. An entry at 10:00 p.m.		the QA committee quarterly. 5. These systemic changes were completed on 2/8/11.	

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	indicated the Nurse Practitioner was in earlier and assessed the resident. A "Medication Error Report" completed on 2/4/11 was reviewed on 5/12/11 at 10:20 a.m. The report indicated Resident #C received an injection of 15 units of Humulin 70/30 that was ordered for Resident #B. The insulin injection was given on 2/4/11 at 3:55 p.m. The physician was notified on 2/4/11 at 4:00 p.m. Orders were obtained on 2/4/11 to check the resident's blood sugar levels every two hours until 10:00 a.m. on 2/5/11. When interviewed on 5/12/11 at 11:20 a.m., the Assistant Director of Nursing indicated she completed the 2/4/11 Medication Error Report. The Assistant Director of Nursing indicated the staff nurse who administered the insulin injection reported the medication error to her immediately after it occurred. When interviewed on 5/12/11 at			

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	1:40 p.m., the Director of Nursing indicated staff are to follow the 6 "Rights of Medication Administration" when administering all medications, which includes administering the medication to the right patient. The Director of Nursing indicated the facility protocol is for nursing staff to identify the resident by name, their picture in the medication books, or by asking another staff member. This federal tag relates to complaint IN00089914. 3.1-48(c)(2)			